Illinois Department of Public Aid

no. : T200-02-1

ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER BULLETIN

10/18/02

TO: Participating Transportation Providers

RE: Handbook for Providers of Transportation Services Update

The purpose of this bulletin is to provide updated pages for the Handbook for Providers of Transportation Services.

The following summarizes the changes being made to the handbook that affect **all** transportation providers.

- T-201.1 – Deletion of vehicle license types.
- New T-202.5 – Directs providers to the Department's website for a list of allowable procedure codes by provider type. This topic also refers the provider to the Provider Information Sheet for rate information.
- T-204 - Clarification of policy when a participant is a hospital inpatient and transportation is required to another facility for outpatient services that cannot be provided at the hospital of origin. Clarification on policy relating to reimbursement for transportation services for any service not covered by Department's Medical Programs.
- T-211 - Clarification of services or participants that are exempt from the prior approval process.
- T-211.1 - The 60-day time limit applied to prior approvals for on-going medical trips to the same source of medical care has been expanded up to 6 months, subject to prior approval by the Department's authorized prior approval agent.
- Appendix T-3 - Correction of payee information. Appendix T-3a, Appendix T-3b and Appendix T-3c have been deleted.

The following changes apply **only** to transportation providers serving Cook, Adams, Brown, Bureau, Calhoun, Cass, Champaign, Christian, Clark, Coles, Cumberland, Dewitt, Douglas, Edgar, Effingham, Ford, Fulton, Greene, Hancock, Henderson, Henry, Iroquois, Jersey, Knox, Lasalle, Livingston, Logan, Macon, Macoupin, Marshall, Mason, McDonough, McLean, Menard, Mercer, Montogmery, Morgan, Moultrie, Peoria, Piatt, Pike, Putnam, Rock Island, Sangamon, Schuyler, Scott, Shelby,Stark, Tazewell, Vermilion, Warren, and Woodford, counties. These are the only areas where the Department's Non-Emergency Transportation Prior Approval Program (NETSPAP) is currently in place.

- T-211.1 - The Department's NETSPAP authorized agent has changed its name from Dyncorp Management Resources, Inc. to DynTek Services, Inc. (DynTek). The address and telephone numbers for DynTek remain the same.

- New T-211.3 – Adds language on form DPA 3076F, Notice of Approval for Transportation Services.

Replacement pages for the Handbook for Providers of Transportation Services are available on the Department's website at

http://www.state.il.us/dpa/provider_release_bulletins.htm

Printed copies are available upon written request to the Department. To ensure delivery, you must specify a physical street address when making a request for a paper copy. Submit your written request by mail or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800
E-mail address is **PPU@mail.idpa.state.il.us**

If you have any questions regarding this bulletin, please contact the Bureau of Comprehensive Health Services at (217) 782-5565.

INSTRUCTIONS FOR UPDATING THE HANDBOOK FOR TRANSPORTATION SERVICES:

Remove pages T-200(i)/T-200(ii), T-201(1)/T-201(2), T-202(3)/T-202(4), T-202(5)/T202(6), T-204(1)/T-204(2), T-211(1)/T-211(2), T-211(3)/T-211(4) and remove Appendices T-3a, T-3b, T3c and T-4, dated October 2001, and insert the replacement pages dated October 2002. The affected paragraphs are designated by "=" signs in the left-hand margin.

CHAPTER T-200
MEDICAL TRANSPORTATION SERVICES
TABLE OF CONTENTS

APPENDICES

T-201 PROVIDER PARTICIPATION

T-201.1 PARTICIPATION REQUIREMENTS

Transportation providers eligible to be considered for participation are those who own or lease and operate any of the following:

- Ambulances licensed by the Illinois Secretary of State and inspected annually by the Illinois Department of Public Health (Vehicle Registration Type Ambulance).
- Helicopters possessing a special EMS license and an FAA Air Carrier Certificate issued by the United States Department of Transportation.
- = Medicars licensed by the Illinois Secretary of State.
- = Taxicabs licensed by the Illinois Secretary of State and, where applicable, by local regulatory agencies.
- = Service cars licensed by the Illinois Secretary of State as livery or public transportation.
- Private automobiles licensed by the Illinois Secretary of State.
- Other specialized modes of transportation, such as buses, trains and commercial airplanes.

Drivers and vehicles must meet the Illinois Secretary of State licensing requirements.

Ambulance providers who provide services within Illinois must be in compliance with the EMS Systems Act (210 ILCS 50). Other transportation provider types based outside of Illinois must provide a valid license, permit or certification from the state where the business is headquartered.

The provider must be enrolled for the specific category of service(s) (COS) for which charges are to be made. The categories of service for which a transportation provider may enroll are:

COS	SERVICE DEFINITION
50	Emergency Ambulance - Transportation of a patient whose medical condition requires immediate treatment of an illness or injury.

The destination of an emergency ambulance is the emergency department of a hospital or another source of medical care when a hospital is not immediately accessible.

Or

Emergency Helicopter - Transportation of a patient when the responsible physician determines such mode to be a medical necessity. Such determination must be documented in writing by the physician.

51 Non-emergency Ambulance - Transportation of a patient whose medical condition requires transfer by stretcher and medical supervision. The patient's condition may also require medical equipment or the administration of drugs or oxygen, etc. during the transport.

52 Medicar - Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp and wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.

53 Taxicab - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

54 Service Car - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

55 Private Automobile - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

56 Other Transportation - Transportation by common carrier, e.g., bus, train or commercial airplane.

Hospitals billing for a helicopter transport team must also submit the claim to the Transportation Prior Approval Unit at the address on the previous page. The claim must also have a physician's written statement that indicates the patient's diagnoses and medical need and the air flight record before approval for reimbursement will be given.

T-202.4 PAYMENT

Payment made by the Department for allowable medical transportation services provided to patients who are not eligible for Medicare will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

Payment made by the Department for ambulance or helicopter transportation services provided to patients who are eligible for both Medicare and Medicaid will be at the lowest of the provider's usual and customary charge or the maximum rate as established by the Department, or the Medicare allowable rate.

Emergency helicopter trips will be reimbursed using an all-inclusive rate depending upon whether the services are for transport team only, helicopter only or transport team and helicopter services.

Helicopter transportation providers who own the helicopter and provide their own transport team will be reimbursed at a maximum rate per trip or the usual and customary charges, whichever is less.

If a hospital provides the transport team but does not own the helicopter, the Department will equally divide the established reimbursement rate or the usual and customary charges of the providers, whichever is less, between the hospital and the helicopter provider.

Hospitals that own their own helicopter and report its costs on their cost reports will not be paid for helicopter transportation services. The Department shall not cover the services of helicopter transportation providers that have entered into payment agreements with receiving facilities.

Emergency helicopter transportation claims that are denied because the patient's condition does not meet medically necessary criteria, will be reimbursed by the Department at the appropriate ground rate.

Ambulance trips will be reimbursed using a base rate and a loaded mileage rate. When Basic Life Support (BLS) is provided, claims made for the administration of oxygen when medically necessary, will be paid at a maximum rate established by the Department.

Advanced Life Support (ALS) trips will be reimbursed using a base rate, loaded mileage rate, oxygen when medically necessary, and all ancillary charges at a maximum rate established by the Department. Payment for ALS is only made to providers who are certified for the service by the Illinois Department of Public Health.

Medicar trips will be reimbursed using a base rate and a loaded mileage rate after the first ten miles of a one-way trip (twenty miles for round trip). Payment for an attendant, that is, a person other than the driver who is employed by the transportation company, and non-emergency stretcher will be made at a maximum rate established by the Department.

Service Car trips will be reimbursed at a base rate and a loaded mileage rate after the first ten miles of a one way-trip (twenty miles for round trip) at a rate set by the Department.

Taxicab trips will be reimbursed at the community rate, as set by local government or if no regulated local government rates exists, at a maximum rate established by the Department.

Private Auto trips will be reimbursed at a loaded mileage rate as set by the Department.

Unique or Exceptional Modes of Transportation will be reimbursed at a negotiated rate.

Billing of excess mileage is not allowed. In performing audits, the Department verifies mileage with a travel route software package.

=T-202.5 FEE SCHEDULE

The Department's list of allowable procedure codes by provider type are listed on the Department's website. The listing can be found at

www.state.il.us/dpa/medicaid_reimbursement.htm

= Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The fee schedule is also available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet. Anytime a change in procedure codes or rates is made, the provider will receive an updated provider information sheet.

T-204 NON-COVERED SERVICES

Certain medical services are not covered in the scope of the Department's Medical Programs and payment cannot be made for transportation to and from such services. Refer to Chapter 100, Topic 104 for a general list of non-covered services. Additionally, payment will not be made by the Department for the following:

- Non-emergency transportation where Department prior approval is required but has not been obtained.
- Services medically inappropriate for the patient's condition (e.g., a taxi when public transportation is available and medically appropriate or a medicar when a service car is warranted).
- Services of a paramedic, emergency medical technician, or nurse in addition to the Department's BLS or ALS rates.
- Transportation of a person having no medical need.
- "No Show" trips (i.e., patient not transported).
- Trips to a pharmacy for filling a prescription.
- Charges for mileage other than loaded miles.
- Transportation of a person who has been pronounced dead by a physician or where death is obvious.
- Charges for waiting time, meals, lodging, parking, tolls.
- Transportation provided in vehicles other than those owned or leased and operated by the provider.
- Transportation services provided for a hospital inpatient who is transported to another medical facility for outpatient services not available at the hospital of origin and the return trip to the in-patient hospital setting. In this instance, the transportation provider must seek payment from the in-patient hospital.
- Transportation to receive services when a patient is a current member of a Managed Care Organization (MCO). Refer to Topic 210.4 for prior authorization information.
- Services provided by a hospital owned and operated transportation provider where the transportation costs are reported in the hospital's cost report for the following:
    - Transportation services provided on the date of admission and the date of discharge.
    - Transportation services provided on the date that an ambulatory procedures listing (APL) service is performed or an emergency room visit is made.

= The Department does not reimburse for transportation provided in connection with any services not reimbursed by the Department's Medical Programs, such as early intervention services, sheltered workshops, day care programs, social rehabilitation programs or day training services. In these instances, transportation providers must verify reimbursement sources prior to delivery of services with the enitity requesting the service.

T-211 APPROVAL FOR NON-EMERGENCY TRANSPORTATION

Except as listed below, prior approval is required for all non-emergency transportation services to and from a source of medical care covered by the Department's Medical Programs.

Prior approval is not required for:

- C Emergency ambulance and helicopter services (category of service 50). NOTE: A **prepayment review** is necessary for all emergency helicopter services. Refer to Topic 202.31
- = • Medical transportation provided for patients who reside in Long Term Care (LTC) Facilities. For purposes of prior approval or requests for transportation services, LTC facilities are defined as:
  - Nursing Facilities or Skilled Nursing Facilities - Provider Type 33
  - Intermediate Care Facilities for the Mentally Retarded (ICF/MR) -Provider Type 29
  - Supportive Living Facilities (SLF) - Provider Type 28
  - State Operated Facilities - Provider Type 34
- C Ambulance service from one hospital for admission to a second hospital to receive inpatient services which are not available at the sending hospital.
- C Ambulance services for Medicare eligible participants, when the trip is allowed by Medicare. If the Medicare intermediary disallows the transportation, post approval must be requested from the Department's authorized transportation approval agent.

In situations when prior approval is not required, providers have the responsibility for verifying the appropriate mode of transportation, the participant's eligibility and the origin and destination prior to accepting the participant for transport.

T-211.1 PRIOR APPROVAL FOR NON-EMERGENCY TRANSPORTATION

= The Illinois Department of Public Aid contracts with DynTek Services Inc. to provide prior approvals of requests for non-emergency transportation services. To request a prior approval, contact DynTek Services Inc. at 1-877-725-0569, TTY 1-800-526-0844, Monday - Friday 8:00 AM - 5:00 PM. Requests for approvals must be made at least two business days prior to the date the transportation service is needed. "Business days" means Monday through Friday and does not include Saturdays, Sundays and holidays. Requests for approvals cannot be made more than seven business days in advance, unless the participant has a standing referral for specific

approved medical services, such as, but not limited to, chemotherapy, radiation therapy, renal dialysis, physical therapy or behavioral health services.

= A standing approval, with a duration of up to 6 months, may be obtained when subsequent trips to the same medical source are required based on standing orders for specific medical services. When approval is sought for subsequent trips to the same medical source, the patient's physician or other health professional must supply the Department's authorized transportation approval agent with a written statement describing the nature of the medical need, the necessity for on-going visits, already established appointment dates and the number and expected duration of the required on-going visits.

Approval Procedures - A request for transportation is initiated to the Department's transportation approval agent by a participant, the transportation provider or the medical services provider.

The approval should be requested as least 2 business days in advance because additional information may be required to make a determination.

The transportation approval agent will require the following information to determine whether the requested transportation is approved:

Name of the participant needing transportation.
Participant's recipient identification number (RIN).
Date and time of the medical appointment.
Medical provider name and address.
Specific purpose of the appointment.
Information to determine the level of transportation needed.
Transportation provider name and provider number.

An approval does not guarantee payment. The participant for whom transportation is approved must be eligible at the time each service is provided.

Approval will be given for the least expensive mode of transportation which is adequate to meet the participant's medical needs. The Department reserves the right for its authorized transportation approval agent to determine the appropriate mode of transportation and if necessary, to assist the participant in obtaining a transportation provider.

Special procedures are used to approve non-emergency medical transportation for children who are in the care and custody of the Illinois Department of Children and Family Services (DCFS). Only DCFS medical liaisons may make non-emergency medical transportation arrangements for DCFS wards. For questions regarding non-emergency medical transportation for a DCFS ward, contact the child's DCFS caseworker or DCFS at 1-800-228-6533.

T-211.2 POST APPROVAL FOR NON-EMERGENCY TRANSPORTATION

In the event it is not possible to obtain prior approval for non-emergency transportation, post approval must be requested. Post approval requests must be received by the transportation approval agent no later than 90 days after the date(s) of service and must include the information required for a prior approval.

Requests for post approvals are subject to the same criteria as those for prior approvals as stated in Topic T-211.1.

Exceptions to the 90 day deadline will be permitted in the following instances:

- The Department or the DHS local office has received the patient's Medical Assistance or KidCare application, but approval of the application has not been issued as of the date of service. In such a case, the post approval request must be received by the approval agent no later than ninety (90) days following the date of the Agency's Notice of Decision approving the application.

- The participant did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received by the approval agent no later than six (6) months following the date of service, but will be considered for payment only if there is attached to the request a copy of the provider's dated, private pay bill or collection correspondence, which was addressed and mailed to the participant each month following the date of service.

- A request for payment was submitted to a third party payer within six (6) months following the date of service. In such a case, a post approval request must be received by the approval agent no later than ninety days from the date of final adjudication by the third party.

=T-211.3 PRIOR APPROVAL NOTIFICATION

If the requested transportation service is approved, the transportation provider will receive a computer-generated letter, form DPA 3076F, Notice of Approval for Transportation Services, listing the approved service(s). The transportation provider must review the Notice of Approval for Transportation Services for accuracy. If there are errors on the Notice, such as incorrect Origin and Destination Codes, DynTek must be contacted to correct the posted approval.

The transportation claim submitted must match the services that appear on the form DPA 3076F, Notice of Approval for Transportation Services, or the claim will be rejected.

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APPENDIX T-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. The Department will mail the sheet to the provider. The sheet serves as the provider's record of all the data that appears on the Provider Data Base.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix T-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

FIELD	EXPLANATION
(1) **PROVIDER KEY**	This number uniquely identifies the provider and must be used as the provider number when billing charges to the Department.
(2) **PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three digit **COUNTY** code identifies the county in which the provider's primary office is located. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
(3) **ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code, the corresponding narrative indicates the provider's classification. 70 = Ambulance 71 = Medicar 72 = Taxicab and Service Car 73 = Other Transportation 74 = Hospital-based Transportation

ORGANIZATION TYPE is a two-digit code with corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code with corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Intent to Terminate
B = Expired License
C = Citation to Discover Assets
D = Delinquent Child Support
F = Fraud Investigations
G = Garnishment
I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested By Provider Participation Unit
T = Tax Levy
X = Tax Suspensions

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/ LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's social security or FEIN number.

6 **PROCEDURE CODE/RATE AND CATEGORIES OF SERVICE**

This area identifies the types of services, procedure(s) and current rate a provider is enrolled to provide.

PROCEDURE CODE - Identifies and defines the specific procedure(s) codes the provider is enrolled to perform. Immediately following the procedure description is the **DATE** the provider has been approved to render services and the reimbursable **RATE** approved by the Department for each listed service rendered by the provider.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:
50 - Emergency Ambulance or Helicopter
51 - Non-Emergency Ambulance
52 - Medicar
53 - Taxicab
54 - Service Car
55 - Private Automobile
56 - Other
Each entry is followed by the date that the provider was approved to render services for each category listed.

=(7) **PAYEE INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider.

If no payee number is designated on a claim form, the Department will reject the claim.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC** # is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services.

(8) **SIGNATURE**

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.